The diffusion of two successful rehabilitation models

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Rössler's article outlines the future direction for rehabilitation psychiatry. I will add some comments on two rehabilitation models – one American and one European – which have proven successful and are diffusing strongly in different parts of the world: the psychosocial clubhouse and the social firm. Though not discussed in Rössler's article, they are likely to play an increasingly important role in psychiatric rehabilitation.

Psychosocial clubhouses like Fountain House, in New York City, and Thresholds, in Chicago, have gained prominence by establishing a model in which people with mental illness are involved in running a programme that meets many of their recreational, social and vocational needs. In the clubhouse setting, clients are referred to as "members" and work with staff in running operations – e.g., putting out the clubhouse newsletter, preparing and serving food, and staffing the reception desk. The clubhouse is open evenings, weekends and holidays, providing a refuge for people who may live in cramped, cheerless housing. Clubhouses are located separately from the mental health agency, and psychiatric treatment is not part of the programme. The emphasis instead is on developing work skills and job opportunities for the members.

Fountain House was founded in 1947 by ex-patients of Rockland State Hospital and for 30 years was the only one of its kind, enjoying an international reputation and entertaining hundreds of visitors each year. In 1976, Fountain House launched a national training program and in 1988 a national expansion effort. The International Center for Clubhouse Development was established in 1994 (1). By 2003, there were over 300 certified clubhouses worldwide: 191 in the USA, 29 in Scandinavia, 23 in Canada, 22 in the British Isles, and others in Australasia, Japan, Korea, Germany and Russia (2).

Foremost among the basic components of the clubhouse model is the so-called "work-ordered day", a structured 8-hour day in which members and staff work side-by-side on clubhouse work units. New members need not volunteer for work until they feel ready but, being assigned to a work group upon enrolment, gentle pressure to become involved is ever present. Another crucial element of the model is the democratic decision-making. Members and staff meet in open session to discuss policy and planning; no staff-only or member-only meetings are permitted. Those who are familiar with the "therapeutic community" model from the 1960s and 1970s will recognize the rehabilitative potential of transferring power from treatment providers to the person with mental illness in this way. Other components are employment programs, such as transitional or supported employment, and community support for members (1,2).

The attractions of the model for people with mental illness, most of whom are not well-off, include good food; a comfortable social environment; a sense of community and mutual support; empowerment, which flows from the democratic philosophy; and access to employment. Observers point to cer-

tain weaknesses, however. The clubhouse movement has conducted almost no randomized control trials and consequently has a weak evidence base. There is, also, a cult-like quality to the clubhouse movement which, for some service organizers, is an obstacle to adoption.

Social firms are businesses created with a dual mission: to employ people with disabilities and to provide a needed product or service. The model was developed for people with mental illness in Italy in the 1970s and, by diffusion, has gained prominence in Europe. In Trieste, Italy, origin of the first social firms, the annual income of the health-service cooperatives in 2004 amounted to $14 million and several additional social firms had been established by non-governmental agencies. The Hotel Tritone, one of the original businesses, has proven particularly successful and a hotel franchising venture is planned. All office- and street-cleaning contracts for the municipality of Trieste are currently awarded to social firms. Over 300 people with mental illness are employed in the Trieste cooperatives as full-wage workers or as trainees.

The first German social firm was founded in 1978: by 2005 there were over 500 such companies in Germany with a combined workforce of 16,500, 50% being disabled. These non-profit companies commonly produce foods, technical products, or services like moving and house-painting (3). Prior to 1997, there were just six social firms in Britain. Since then, the number has grown to 49 financially independent businesses, plus 70 "emerging" social firms that still require a subsidy. In 2005, British social firms were employing over 1,500 people, two-thirds being disabled, mostly with mental disabilities. Catering and horticulture are the largest business sectors (4). Technical assistance provided by Italian and German support organizations to Social Firms UK, another support entity, has fostered this growth (3). Independent of European influence, social firms have also developed in Canada and the US. Virtually all of the psychiatric work rehabilitation services in Toronto, Ontario, are offered through social firms, and most of these businesses are operated solely by people with mental illness. Social firms have also been developed in Japan and Korea, free of European influence.

The success of individual social firms is enhanced by locating the right market niche, selecting labour-intensive products, the public orientation of the business, and links with treatment services. The growth of the social-firm movement is aided by an advantageous legal framework, policies favouring employment of the disabled, and support entities that facilitate technology transfer. Advantages of the social-firm model include opportunities for empowerment, the development of a sense of community in the workplace, and worker commitment resulting from the organization's social mission.

Time will tell if these rehabilitation models will continue to diffuse at the same rate as recently. If they do, they will become substantial elements of rehabilitation psychiatry in the future.

References

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